STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

I. General Provisions

09/91 A. Scope

== 10/93 1. Effective October 1, 1992, the Department shall reimburse hospitals for inpatient services rendered to persons receiving coverage under the Medicaid Program by either: 1) a Diagnosis Related Grouping System (DRGs) prospective payment system (PPS), 2) a cost-based per diem system, or 3) a noncost-based per diem system. All three reimbursement systems are prospective in nature and hospitals may keep the difference between their payment rate and the actual costs incurred in furnishing inpatient services and are at risk for costs that exceed their payment rates. Additional payments will be made for outlier cases, certain costs excluded from the prospective payment rate, disproportionate share hospitals, uncompensated care, specific inpatient adjustments, primary care access health care education, certified registered nurse anesthetist (CRNA) costs, and for kidney acquisition costs.

== 10/93 2. Notwithstanding any other provisions of Chapters I. through XIV., reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:

== 10/93 a. Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1993, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under the following Chapters: Chapters I. through V., Chapter VI., Section G., and Chapters VII. through VIII.

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b. Exceptions. The provisions of Section A.2.a. above shall not apply to:

i) Hospitals reimbursed under Chapters X., XIII., or XIV. Reimbursement for such hospitals shall be in accordance with Chapters X., XIII., or XIV., as applicable.

ii) Hospitals reclassified as rural hospitals as described in Section H.4. of Chapter VIII.. Reimbursement for such hospitals shall be in accordance with Section H.4. of Chapter VIII., and Section A.2. of Chapter VIII., or Section B.2. of Chapter IV., whichever is applicable.

iii) The inpatient payment adjustments described in Chapter VI., Sections A. through F. Reimbursement for such inpatient payments adjustments shall be in accordance with Chapter VI., Sections A. through F., and shall be in addition to the base inpatient payment rate described in Section 2.a. above.

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10/92 B. Summary

This Chapter describes the basis of payment for inpatient hospital services under the DRG PPS and sets forth the general basis for the system. Chapter II. sets forth the classifications of hospitals that are included and excluded from the DRG PPS and sets forth requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification. Chapter III. sets forth certain conditions that must be met for a hospital to receive payment under the DRG PPS. Chapter IV. sets forth the methodology by which DRG prospective payment rates are determined. Chapter V. sets forth the methodology for determining additional payments for outlier cases. Chapter VI. sets forth rules for special treatment of certain facilities. Chapter VII. describes the types, amounts and methods of payment to hospitals under the DRG PPS. Chapter VIII. describes the payment for hospitals subject to alternative reimbursement systems. Chapter IX. describes the review procedures for payment reviews. Chapter X. describes reimbursement for transplant care, Chapter XI. describes reimbursement for inappropriate level of care and Chapter XII. describes alternatives. Chapter XIII. describes reimbursement for county-owned hospitals in a county with a population of over 3 million. Chapter XIV. describes reimbursement for state-owned hospitals organized under the University of Illinois Hospital Act. Chapter XV. describes definitions and applicability of terms used throughout this plan.

09/91 C. Basis of Payment

1. Payment on a Per Discharge Basis

Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

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10/92 The DRG prospective payment rate for each discharge (as defined in Section D. of this Chapter) is determined according to the methodology described in Chapters IV. and VII., as appropriate. An additional payment is made, in accordance with Chapter V. and Chapter VI., as appropriate. The rates paid shall be those in effect on the date of admission.

2. Payment in Full

a. The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs (as described in Section C.3. below) incurred in furnishing services covered under the Medicaid Program.

b. Except as provided for in Section D. of this Chapter, the full DRG prospective payment amount, as determined under Chapters IV. and VII., as appropriate, is made for each stay during which there is at least one Medicaid eligible day of care.

3. Inpatient Operating Costs

The DRG PPS provides a payment amount for inpatient operating costs, including:

a. Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;

b. Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

c. Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990); and

d. Malpractice insurance costs related to services furnished to inpatients.

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10/93 e. Hospital-based physician costs as described in Section G. of Chapter III.

4. Excluded Costs/Services

The following inpatient hospital costs are excluded from the DRG prospective payment amounts:

==07/95 a. Transplantation costs, including acquisition costs incurred by approved transplantation centers as described in Chapter X. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Chapters IV. and VII., or in Chapter VIII., Chapter XIII. or Chapter XIV., as appropriate.

10/92 b. Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed in accordance with Chapter VIII., Chapter XIII., or Chapter XIV., as appropriate.

c. Costs of nonemergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.

d. Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRG's 424-432). Such services exceeding the maximum of three days shall not be eligible for reimbursement.

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10/92 e. Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed in accordance with Chapter VIII., Chapter XIII., or Chapter XIV., as appropriate.

10/92 f. Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall not be reimbursed as hospital services.

5. Additional Payments to Hospitals

In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:

a. A typically long or extraordinarily costly (outlier) cases, as described in Chapter V.

b. Certain costs excluded from the prospective payment rate under Section C.4. of this Chapter.

10/92 c. The cost of serving a disproportionately high share of low income patients (as defined and determined in Chapter VI.).

==07/95 d. Specific inpatient payment adjustments (as defined and determined in Chapter VI. and Chapter XV.).

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09/91 D. Discharges and Transfers

1. Discharges

A hospital inpatient is considered discharged when any of the following occurs:

a. The patient is formally released from the hospital except when the patient is transferred to another hospital or a distinct part unit as described in Chapter II. (see section D.2. of this Chapter).

b. The patient dies in the hospital.

2. Transfers

A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Chapter II.

3. Payment in Full to the Discharging Hospital

10/92 The hospital discharging an inpatient (under Section D.1.a. of this Chapter) is paid in full, in accordance with Section C.2. of this Chapter unless the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS as described in Chapter II. In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with Chapter VIII., Chapter X., Chapter XIII., or Chapter XIV., as appropriate.

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4. Payment to a Hospital Transferring an Inpatient to Another Hospital or Distinct Part Unit

a. A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in Section D.2., is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Chapter IV. if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Chapter IV.) by the geometric length of stay for the specific DRG to which the case is classified.

b. Except, if a discharge is classified into DRG 385 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with Section C.2. of this Chapter.

c. A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Chapter V.

10/92 d. A hospital or distinct part unit excluded from the DRG PPS, as described in Chapter II., that transfers an inpatient under the circumstances described in Section D.2. of this Chapter, is reimbursed in accordance with Chapter VIII., Chapter XII., Chapter XIII., or Chapter XIV., as applicable.

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09/91 E. Admissions Prior to September 1, 1991

With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991, for each covered day of care provided through the discharge of the patient.

09/91 F. DRG Classification System

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1. The Department will utilize the DRG Grouper, as described in Section B.5. of Chapter XV., modified to handle additional DRG's and revised ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.

2. The Department will define additional DRG's that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).

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II. Hospital Services Subject to and Excluded from the DRG Prospective Payment System

09/91 A. Hospital Services Subject to the DRG Prospective Payment System

1. Except for services described in Section C.4. of Chapter I. and Section B.2. of this Chapter, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.

2. Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:

a. The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under Sections C. through D. of this Chapter.

b. The services are furnished by a nonparticipating out-of-state hospital (as described in Section C.5. of this Chapter).

c. The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in Section C.6. of this Chapter) in the transition period of DRG PPS implementation.

10/92 d. The services are furnished by a sole community hospital (as defined in Chapter VI.B.1.) that has elected to be exempted from the DRG PPS in accordance with Section C.7. of this Chapter.

e. The payment for services is covered by a health maintenance organization (HMO).